HW0766 (7/04)

DEPARTMENT OF HEALTH AND WELFARE

Region _____ Field Office _____

Date Received _____

APPLICATION FOR CHILDREN'S DEVELOPMENTAL SERVICES

Date: _____

Name: _____ Date of Birth: _____ SSN: _____

Is the child currently enrolled in Medicaid? ☐ Yes ☐ No If Yes, MID# _____ Healthy Connections? ☐ Yes ☐ No

Parent(s) Name: _____ Telephone: _____

Address: _____

_____

Physician Name: _____ Telephone: _____

Physician Address: _____

Name of School, if applicable: _____

Services being sought:

☐ Service Coordination ☐ Family Support ☐ Infant Toddler Services ☐ DDA ☐ Intensive Behavioral Intervention (IBI)

☐ ICF/MR Level of Care for ICF/MR or Katie Beckett ☐ Other (specify) _____

_____

Person Requesting Services: _____ Relationship to Applicant: _____

Other DHW services the child receives: ☐ Service Coordination ☐ Family Support ☐ Infant Toddler Services ☐ DDA ☐ IBI ☐ PSR

List enrollment in any other services, including other Department services: _____

_____

_____

History/Information about concern or disabling condition: _____

_____

_____

Please check which of the following information is available: ☐ Medical records verifying disability ☐ School records verifying disability

Please also attach the most recent evaluations: Medical/Social, Developmental, Speech and Language, Physical Therapy, Occupational Therapy, and other pertinent evaluations. If the information is held by another agency, please indicate the source below. Your authorization for release of information may be requested. Information provided to the Department will be treated in accordance with the Department Notice of Privacy Practices. _____

_____

☐ Service Coordination	☐ Approved	☐ Denied
☐ Family Support	☐ Approved	☐ Denied
☐ Infant Toddler Services	☐ Approved	☐ Denied
☐ DDA Services	☐ Approved	☐ Denied
☐ Intensive Behavioral Intervention	☐ Approved	☐ Denied
☐ ICF/MR Level of Care	☐ Approved	☐ Denied

If applicable, reason for denial, including Idaho Code or IDAPA rule citation: _____

_____

_____

Signature of Authorized Representative of the Department:

_____ Date: _____

Notification of your right to appeal this decision is on the reverse side of this form.

RIGHT TO APPEAL:

Applicants for or recipients of services have a right to a hearing any time a decision is made that substantially affects benefits. The applicant or recipient has a right to be represented by legal counsel or any spokesperson he chooses to designate. The client or his representative must request a hearing in writing and include the following information:

- Copy of the decision with which the applicant or client disagrees
- Applicant or client name
- Address and phone number
- Reasons for challenging the Department's decision
- Remedy requested

Hearing requests must be turned in or mailed to the address below:

Hearings Coordinator
Department of Health and Welfare
450 West State, 10th Floor
P. O. Box 83720
Boise, ID 83720-0036

The Idaho Department of Health and Welfare will provide a hearing request form when requested by the recipient or a representative. The request for a hearing must be submitted within twenty eight (28) days from the date the notice of decision was mailed by the Department. The Hearing Officer will notify the recipient or representative of the date, time, and place of the hearing at least ten (10) days before the scheduled hearing, unless the Hearing Officer finds good cause for shorter notice. Hearing rights and procedures relating to hearings are found at IDAPA 16.05.03, Rules Governing Contested Case Proceedings and Declaratory Rulings.